New York State Department of Health

Health Care Facility
Infection Control (Nosocomial) Report

Facility Name: _____ PFI (4-digit facility # required): _____

Street Address: _____ Census: _____

Street Address: _____

City: _____ County: _____

Zip Code: _____ Region: _____

Type: Hospital ☐ LTCF ☐

Contact Person: _____ Phone Number: _____

Title: _____ Fax Number: _____

E-Mail: _____

Date of Report: _____

Type of Report:
- ☐ Outbreak/Increase incidence
- ☐ Single case nosocomially-acquired reportable communicable disease *(submission of DOH-389 is required)*
- ☐ Other: _____

Site or Sites of infection:
(check all that apply)

☐ Blood ☐ Eye ☐ Gastrointestinal ☐ Other: _____
☐ Respiratory ☐ Skin ☐ Urinary

DATE OF ONSET OF SYMPTOMS: (earliest case) _____

PREDOMINANT SYMPTOMS AND DURATION OF ILLNESS: (if fever, include range) _____

_____

_____

NUMBER OF LABORATORY CONFIRMED CASES TO DATE: Patients: _____ Staff: _____

NUMBER OF SUSPECT CASES TO DATE: Patients: _____ Staff: _____

NUMBER TRANSFERRED TO HOSPITAL: Patients: _____ Staff: _____

NUMBER OF CASES RESULTING IN DEATH: Patients: _____ Staff: _____

AFFECTED LOCATION(S) IN FACILITY:

Number of Units : _____ Number of Floors: _____

AFFECTED LOCATION TYPES: (applies to hospitals only)

☐ Cardiac ☐ General Medical ☐ Med\Surg ☐ Surgical
☐ Nursery ☐ OB/GYN ☐ Oncology ☐ Not Applicable
☐ Ortho ☐ Pediatrics ☐ Rehab ☐ Other: _____

AFFECTED ICU TYPES:

☐ Cardiac ☐ General ☐ Medical ☐ Surgical ☐ Other: _____
☐ Neonatal ☐ Neurological ☐ Pediatrics ☐ Not Applicable

AFFECTED TRANSPLANT UNIT TYPES:

☐ Bone Marrow ☐ Cardiac ☐ Not Applicable
☐ Renal Cardiac ☐ Liver ☐ Other: _____

OTHER UNIT TYPE: _____

CAUSATIVE AGENT: _____

SUSPECT/CONFIRMED: ☐ Suspect ☐ Confirmed

HAVE ANY LABORATORY SPECIMENS BEEN COLLECTED:

☐ Yes ☐ No

If yes, what specimens were collected? (check all that apply):

☐ Blood ☐ CSF ☐ Nasal Pharyngeal ☐ Urine

☐ Sputum ☐ Stool ☐ Tracheal Aspirate ☐ Other: _____

If yes, what types of tests were performed? (check all that apply):

☐ Culture ☐ PCR ☐ Rapid Antigen

☐ Serology ☐ Urine Antigen ☐ Other: _____

Name of Laboratory: _____

CONTROL MEASURES TAKEN BY FACILITY (check all that apply):

☐ Antibiotics ☐ Antiviral ☐ Cohort Patients ☐ Cohort Staff

☐ Education/Inservice ☐ Isolation ☐ Limit/modify patient activities ☐ Minimize Floating

☐ Notify Visitors ☐ Reinforced Handwashing ☐ Other: _____

Additional control measures not checked above: _____

_____

_____

_____

_____

_____

FOR OFFICE USE ONLY

No Close-out Form for this case (ex Scabies): ☐

Paper Log Number: _____ Level of Investigation: _____

Date Received: _____ Lead Investigator: _____

Received by: _____ Follow-up by: _____

Central Office Contact to Facility: ☐ Yes ☐ No If yes, date: _____

Regional Epidemiology Staff Contact to Facility: ☐ Yes ☐ No Date of Initial Contact:: _____

Comments: _____

_____

_____

_____

_____

_____

_____

Stat: ☐

Please FAX to 518-408-1745 _____